BOSTON INSPECTIONAL SERVICES
DIVISION OF HEALTH INSPECTIONS
1010 MASSACHUSETTS AVENUE
BOSTON, MA 02118
(617) 635-5326
FAX (617) 635-5388

PRACTICE OF MASSAGE

TO OBTAIN A LICENSE FROM THE DIVISION OF HEALTH INSPECTIONS YOU MUST HAVE THE FOLLOWING:

1. YOU MUST BE A GRADUATE OR A STUDENT OF AN AMTA OR ABMP SCHOOL WITH A MINIMUM OF 500 HOURS OF INSTRUCTION. IF YOU ARE A STUDENT, YOU MUST PROVIDE A LETTER OF SUPERVISION FROM A LICENSED MASSAGE THERAPIST.

2. YOU MUST PROVIDE PROOF OF GRADUATION AND TRANSCRIPTS.

3. PROVIDE PROOF OF MEDICAL EXAMINATION WITHIN THE LAST 30 DAYS OF FILING. APPLICATION MUST CERTIFY THAT YOU ARE FREE OF COMMUNICABLE DISEASE TRANSMITTED BY THE PRACTICE OF MASSAGE.

4. TWO (2) PASSPORT SIZE PHOTOGRAPHS (2" X 2") MUST BE SUBMITTED WITH THE APPLICATION.

5. YOU MUST PROVIDE WRITTEN PROOF OF AGE (BIRTH CERTIFICATE OR DRIVER'S LICENSE)

6. COMPLETE A HEALTH DIVISION APPLICATION. APPLICATIONS ARE ACCEPTED MONDAY THROUGH FRIDAY, 8:00 AM – 4:00 PM.

7. HEALTH DIVISION LICENSE FEE IS $50.00

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PRACTICE MASSAGE _____ OFF PREMISES MASSAGE _____ STUDENT _____
FIXED BUSINESS ESTABLISHMENT CLIENT'S HOME OR BUSINESS

TYPE OF MASSAGE TO BE PRACTICED _____

APPLICANT'S FULL NAME: _____
HOME ADDRESS: _____
NO. STREET
_____
TOWN/CITY STATE ZIP CODE

HOME PHONE NUMBER _____ BUSINESS PHONE NUMBER _____

BUSINESS NAME: _____

BUSINESS ADDRESS: _____
NO. STREET
_____
TOWN/CITY STATE ZIP CODE

IS YOUR BUSINESS INCORPORATED? YES: ____ NO: _____

PROOF OF AUTHORITY TO DO BUSINESS IN MA SUBMITTED: YES: ____ NO: ____
TAX NUMBER: _____

ALL RESIDENTIAL ADDRESSES OF APPLICANT FOR THE PAST FIVE (5) YEARS:
_____

_____

_____

AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT:_____ HAIR COLOR: _____ EYE COLOR: _____

TWO (2) PHOTOGRAPHS 2" X 2" MUST BE SUBMITTED: YES: ____ NO: ____

PROOF OF MEDICAL EXAMINATION BY A **LICENSED PHYSICIAN** SUBMITTED WITHIN THIRTY (30) DAYS: YES: ____ NO: ____

FORMER OCCUPATIONS OR MASSAGE OCCUPATIONS OF APPLICANT FOR PAST THREE (3) YEARS:

OCCUPATION NAME OF BUSINESS AND ADDRESS
_____

_____

_____

LIST ALL CRIMINAL CONVICTIONS, FORFEITURES OF BOND, OR PLEA OF NOLO CONTENDERE, EXCLUDING TRAFFIC, MISDERMEANOR OR INFRACTION VIOLATIONS:

_____

_____

_____

WHAT EDUCATION, TRAINING AND EXPERIENCE HAVE YOU HAD TO QUALIFY YOU TO PRACTICE MASSAGE?

_____

_____

_____

DIPLOMA AND TRANSCRIPTS RECEIVED: YES: ___ NO: ___

HAVE YOU HAD A LICENSE OR PERMIT TO PRACTICE MASSAGE SUSPENDED OR REVOKED BY ANY AGENCY OR BOARD, CITY, COUNTY OR STATE? YES: ____ NO: ____
IF YES, EXPLAIN: _____

_____

_____

AT WHAT PLACE OR PLACES OTHER THAN THE HOMES OR BUSINESSES OF PATRONS DO YOU WISH TO BE LICENSED TO PRACTICE MASSAGE?

BUSINESS NAME ADDRESS

_____

_____

_____

I AUTHORIZE AND RELEASE THE DEPARTMENT TO SEEK INFORMATION OR REFERNCE NECESSARY TO VERIFY THE INFORMATION CONTAINED IN THE APPLICATION:

_____ _____
SIGNATURE OF APPLICANT SOCIAL SECURITY NUMBER

I CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION IS TRU AND CORRECT. ANY MISSTATEMENTS IN THIS APPLICATION ARE GROUNDS FOR REFUSING TO ISSUE OR FOR REVOCATION OF ANY LICENSE ISSUED.

_____ _____
SIGNATURE OF APPLICANT SOCIAL SECURITY NUMBER